

Matching Drug-Involved Probationers to Appropriate Drug Interventions: A Strategy for Reducing Recidivism

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FOR CLOSE to two decades, probation and parole agencies have been struggling with large caseloads of drug-involved offenders. This is especially true in areas such as New York City, where drug-related arrests have risen sharply and community corrections has had to expand in order to alleviate overcrowding in jails and prisons. Probation and parole departments have emphasized two main approaches to manage high-risk clients with serious drug problems and criminal records. Many of these agencies have established intensive or specialized drug supervision units that monitor clients' drug use with urine testing and refer those who test positive to drug treatment programs. In the last several years, a number of agencies also have begun contracting with community-based drug treatment programs as a means of having greater access to treatment resources (outpatient slots and residential beds) and more control over clients. How well suited are these approaches for managing drug-involved offenders?

Unfortunately, the answer is not as simple as one would like to provide to policymakers and probation and parole officials. In brief, evaluation studies of intensive or specialized supervision programs have produced, at best, mixed results. Probationers under intensive as well as regular supervision recidivate at high rates, and many of them are subsequently incarcerated. Langan and Cunniff (1992), for example, report that about half of the felony probationers in a national sample sentenced in 1986 had been incarcerated or had absconded within 3 years of sentencing. The vast majority of these cases were drug-involved. Evaluation studies of over a dozen intensive supervision programs have found that many of them are not effective in reducing recidivism (Petersilia & Turner, 1993). As Petersilia and Turner (1990) note, this may be because these programs do not place a great enough emphasis on drug treatment.

Evaluation studies have shown that clients who participate in drug treatment programs, including methadone maintenance, residential, and outpatient programs, have significantly lower rates of recidivism and drug relapse than

do control groups (Anglin & Hser, 1990). Clients who stay in treatment longer are significantly less likely to relapse and recidivate than those who drop out earlier. Indeed, for clients in outpatient drug treatment programs, rates of rearrest and relapse are significantly lower if they stay in treatment for more than 3 months than if they drop out earlier (Hubbard, Rachael, Craddock, & Cavanaugh, 1984). It must be noted that most clients leave treatment before this time. While research generally finds that drug treatment is effective in reducing recidivism among clients mandated to treatment, it has not specifically addressed whether contracting with programs improves outcomes for criminal justice clients.

The main thrust of evaluation studies of intensive (or specialized) supervision and drug treatment programs that serve offenders has been on assessing their effectiveness. Unfortunately, the one consistent finding of all this research is that many offenders relapse and recidivate. Even when programs are effective, even when recidivism rates are significantly lower—as they often are—among drug treatment clients than among control cases, a sizable number of clients drop out and many of them are rearrested, usually within about a year. Since neither of these strategies—intensive supervision or outpatient drug treatment—appears to be successful with many offenders, then continuing to ask whether particular programs are effective may be asking the wrong question. A better question to ask is “For which kinds of offenders are these approaches appropriate?”

This article is intended to provide policymakers and community corrections administrators with insight into why it is important to match clients to appropriate forms of treatment and how this might be done. The basic point is that when appropriate interventions (e.g., residential drug treatment, outpatient treatment, urine monitoring) are used with drug-involved clients, scarce treatment resources are utilized more effectively in reducing recidivism and relapse. Just as community corrections has long given priority to classifying probationers and parolees to appropriate levels of supervision, these agencies can develop guidelines for referring clients to appropriate treatment modalities. We demonstrate the value of matching clients to appropriate treatment interventions by presenting findings from an evaluation study of the New York City Department of Probation's drug treatment initiative. The main findings follow a brief description of the city's drug treatment initiative as it existed in the early 1990s.

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New York City's Anti-Drug Initiative

The New York City Department of Probation's strategy for managing drug-involved probationers involved a combination of specialized supervision caseloads and contracts with outpatient drug treatment programs. In 1989, the probation department established SAVE (Substance Abuse Verification and Enforcement) Units. These specialized units were created to provide closer supervision of high-risk, cocaine-abusing probationers by having lower caseloads than regular units and by developing stronger linkages with community-based drug treatment programs. In practice, SAVE caseloads were comprised of probationers at various risk levels (though mainly the two highest of four levels), with cocaine use representing only about half the cases. The average caseload for SAVE units was about 65 probationers per officer, whereas the caseload for regular probation officers was between 150 and 175.

In 1991, the department created a Central Placement Unit (CPU), which contracted with nine outpatient drug-free treatment programs for 965 treatment slots intended primarily for cocaine-abusing probationers.¹ Probationers who were identified as users of drugs other than cocaine also could be referred to treatment through the CPU. Referrals were made through the CPU, which operated like an 800-number reservation service that probation officers could call to place clients in contracting treatment programs. Twelve months was the recommended course of outpatient treatment. The average cost per slot (person-year of treatment) was about \$4,000. The contracts paid programs for providing the department with intake, treatment services, and information about clients. The treatment programs were to notify probation officers (within 24 hours) whether the probationers showed up for intake and provide the CPU with a four-page intake report, monthly progress reports, timely communication if the probationer failed to appear for treatment and was at risk of being discharged from the program, and a termination form.

Department policy required that all high-risk (levels 1 and 2) probationers receive mandatory urinalysis within the first 2 weeks of entering supervision, regardless of whether they were known to have a history of drug use. Probationers who initially tested negative then received a second urinalysis within another 2 weeks. Probationers who tested positive on either of these tests were supposed to be referred to drug abuse treatment as were clients who had a court-ordered drug condition. Though the CPU was intended to serve primarily SAVE cases, probation officers managing clients on regular supervision also could access treatment resources through the CPU. Both SAVE and regular probation officers continued to refer clients directly to non-contracting treatment programs. The contracting drug treatment programs were required to conduct regular urinalysis and report the results to the CPU. The probation department, however, could not require non-contracting treatment programs to test clients regularly or to report the test results to probation officers (though some programs did this voluntarily).

Evaluation Research Findings

We found, overall, that New York City's drug treatment initiative was effective. Outpatient drug treatment was related to significant reductions in recidivism among clients referred through the CPU, with the greatest reduction in recidivism among those CPU clients who were appropriately matched to outpatient drug treatment on the basis of the severity of their drug use. The following paragraphs summarize the main findings of the process and outcome evaluation (for a more detailed explanation of the statistical methods and findings, see Falkin, Strauss, Bohlen, Young, & Winterfield, 1997).

The CPU was an innovative strategy for meeting the considerable need for drug treatment among probationers. The CPU was an important innovation, improving on the past practice which required that probation officers individually identify non-contracting programs that would admit each of their clients who needed treatment. The CPU represented a systematic approach, enabling probation officers to refer clients to a variety of contracting outpatient drug treatment programs with guaranteed slots. The CPU was a significant effort in that the probation department contracted for enough slots to make nearly 2,000 referrals for probationers who needed drug treatment.

Even though the CPU contracts served many drug-involved probationers, slots were available for only a portion of the clients who needed drug treatment. About three-quarters of the probationers in New York City used drugs before being arrested (National Institute of Justice, 1995), and about two-thirds of intensive supervision cases were using drugs, mainly cocaine, while on probation (Wish, Brady, Cuadrado, & Martorano, 1986). Conservatively, we estimate that at least one-quarter of the roughly 20,000 new probationers who entered the system in the year the CPU was established were in need of drug treatment (Falkin et al., 1994). Less than one-tenth (N=1,860) of the individuals sentenced to probation during the first year of the CPU's operation (September 1991 to September 1992) were referred to contracting outpatient drug treatment programs one or more times as of December 31, 1993. It is not known how many probationers were referred to non-contracting (residential, drug-free outpatient, or methadone) treatment programs.²

The implementation of the CPU was a success in the final analysis, though it appears that many of the cases referred to treatment may not have been high-risk, cocaine-dependent probationers, as originally intended. Although the CPU was intended to serve cocaine-dependent probationers, primarily those on SAVE supervision units, this did not actually happen. Only about 20 percent of the cases referred through the CPU were SAVE cases. The 362 SAVE cases referred through the CPU represent about 30 percent of all SAVE cases (N=1,243). While the CPU also was intended to serve high-risk probationers, about one-third of the CPU referrals were classified as relatively low risk (levels 3 and 4). It is not possible to know exactly what information about their clients' cocaine use (i.e., presen-

tence investigation reports or drug testing results) was available to probation officers at the time they referred cases through the CPU. (We estimate that approximately half of the CPU cases were not known to be cocaine users at the time of referral.) Although the CPU was intended primarily for high risk, cocaine-dependent probationers, the fact that the CPU actually served many probationers with less serious problems should not be viewed as problematic. As we show below, referring more cocaine abusers to outpatient treatment may not have been appropriate and would have reduced the effectiveness of the effort.

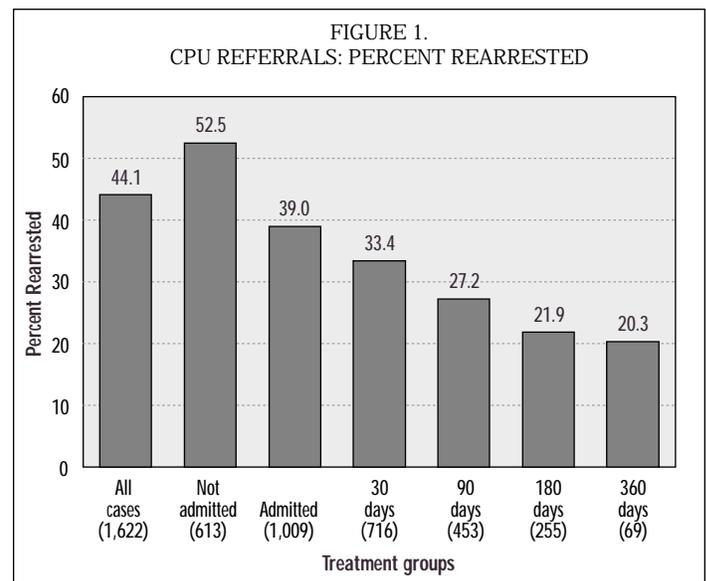
Most cases referred to treatment through the CPU did not get much treatment—either they were not admitted or they dropped out within a few months. Over one-third of the cases referred through the CPU failed to appear at treatment intake or were not admitted. Among those who were admitted, the length of time that clients stayed in treatment varied considerably, with retention rates being fairly low overall. Retention in treatment ranged from 1 day to about 2 years, with only 5 percent of probationers remaining for the recommended 1 year of drug treatment. About one-fifth of the probationers dropped out of treatment in less than 2 weeks and slightly more than half dropped out within 3 months. The mean retention rate (which was a little over 3 months) is comparable with retention rates for other outpatient samples serving mandated clients (Hubbard et al., 1984).

Client participation in outpatient drug treatment was low. On average, clients attended only about half (about 1.5 hours per week) of their scheduled treatment sessions. Although the length of time clients stay in treatment provides one indication of the amount of treatment that clients receive, actual attendance at treatment sessions can vary considerably among outpatient clients. Client participation in treatment, as measured in terms of the number of hours of treatment and the number of sessions that clients attended, also was very low (Hawke & Falkin, 1995). Probationers participated in only about half of their scheduled treatment activities. On average, all the clients were scheduled for an equivalent of about 10 hours of treatment per month, but they attended an average of only about 5 hours per month. Clients who stayed in treatment longer also were more actively involved in the treatment process in that they attended more hours/sessions weekly than those who dropped out earlier. Though clients who stayed in treatment longer (e.g., over 3 months) actually received substantially larger “doses” of treatment than dropouts, the “dosages” were still fairly low.

Contracting with outpatient drug treatment programs was an effective strategy for reducing recidivism. Three-quarters of the probationers admitted to contracting programs had fewer arrests during the year following discharge from treatment than during the year before they were sentenced to probation. Furthermore, as figure 1 shows, clients who were admitted to treatment had significantly lower rearrest rates than those who were referred but not admitted. Although 44 percent of all the CPU cases referred to treatment between September 1991 and December 1993

were rearrested by December 31, 1994, 53 percent of those who were not admitted to treatment were rearrested. In contrast, only 39 percent of those who were admitted to treatment were rearrested. (These percentages include all rearrests from the time of sentencing until the cutoff period for the recidivism data.)

Clients who stayed in outpatient drug treatment longer than 90 days were significantly less likely to recidivate than those who dropped out earlier. Figure 1 also shows that the percent of probationers who were rearrested declined as the length of stay in treatment increased. Clients who stayed in treatment longer were significantly less like-



ly to recidivate than those who dropped out earlier. Among those who were admitted to treatment, about half of the probationers who stayed in treatment less than 3 months were rearrested, while only about one-quarter of those who stayed longer were rearrested.

Because the time period for measuring rearrest varied among the cases, we standardized rearrest as an annual rearrest rate. We were not able to control for time at risk because we did not have data to determine when probationers were in jail. Figure 2 shows the annual rearrest rate for all crimes in relation to the number of days of treatment. (The rearrest rate for clients not admitted to treatment is measured from the date of sentence to probation; the rearrest rate for the other group is measured from the date of admission to drug treatment.) The pattern for the rearrest rate is similar to the one for the percent of clients rearrested. The annual rearrest rate for the group not admitted to treatment is .385, which is significantly higher than the .311 rearrest rate for the group admitted to treatment.

The rearrest rate declines significantly as the length of time clients stay in treatment increases. The clients who stayed in treatment for more than 90 days had a significantly lower rearrest rate (mean = .198) than those who were either not admitted or dropped out earlier. Among those

who were arrested, the group that stayed in treatment longer also was significantly less likely to be incarcerated, and the length of time until rearrest was significantly longer. Multiple regression analyses also showed that clients who stayed in drug treatment for more than 90 days had significantly fewer rearrests for drug offenses and violent crimes.

Other factors also were examined for their possible influence on rearrest rates. The number of prior arrests was the strongest predictor of rearrest. Younger probationers and men were found to have higher rearrest rates than older probationers and women. The age at first arrest was positively related to rearrest. Controlling for these variables, time in treatment was still a significant predictor of rearrest. Clients who stayed in treatment 90 days or more had significantly lower rearrest rates than others, including probationers who were referred but not admitted and those who dropped out within 90 days after being admitted to treatment. The addition of other client variables (e.g., severity of drug use, types of drugs used, drug use among family members, employment, marital status, race/ethnicity, risk level, and other measures of prior criminal record) did not significantly explain any more of the variance in rearrest rates than did the preceding variables.

Specialized SAVE supervision was no more effective in curbing recidivism than regular supervision. We also compared SAVE supervision with regular supervision by entering the type of supervision as an independent variable in each of the multiple regression models. In all these analyses, recidivism rates were never lower for probationers in SAVE units.

Outpatient drug treatment was not appropriate for about one-quarter of the probationers referred through the CPU because the severity of their drug use indicated a need for residential treatment. Using the Offender Profile Index (OPI), a clinical assessment instrument designed for matching criminal justice clients to various drug interventions (Inciardi, McBride, & Weinman, 1993), we separated the CPU clients into three groups according to their probable need for differ-

ent interventions: residential drug treatment, outpatient drug treatment, or urine monitoring only. The OPI assigns clients to these various interventions on the basis of the severity of their drug use and a number of aspects of their "stakes in conformity" (which includes criminal involvement, drug treatment histories, job situation, education, and housing).

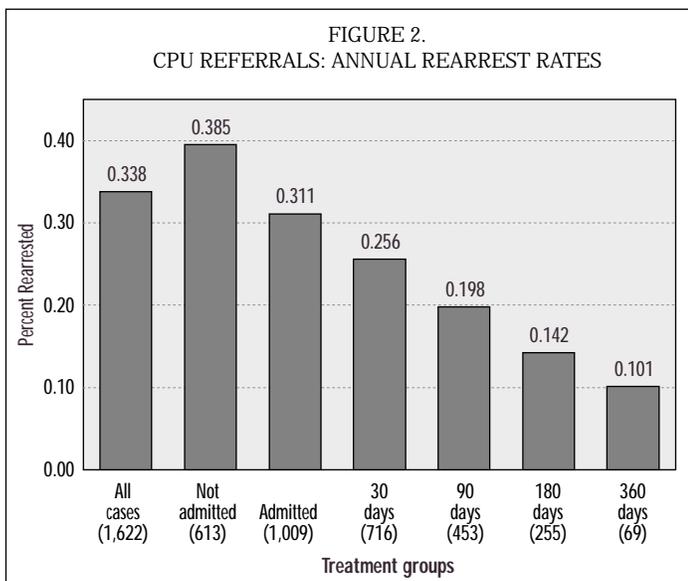
Data from the presentence investigation drug assessment were mapped retrospectively onto the OPI drug use severity index in order to determine the severity of each probationer's drug use and to provide an appropriate treatment recommendation. About one-quarter of the CPU cases had severe drug problems (i.e., injecting drugs or using cocaine, crack, or amphetamines once a week or more). According to the OPI criteria, these cases required long-term or short-term residential treatment.

Two-thirds of the sample only needed urine monitoring on the basis of their OPI assessment of drug use and social conformity. This group was comprised of individuals who either only used alcohol or marijuana or used PCP or barbiturates on a very limited basis (less than once a week). (If PCP or barbiturates are used more frequently, urine monitoring also is indicated, provided that there is an acceptable degree of social conformity.) Thus, on the basis of information available in the presentence investigation report, the majority of the sample were not hard-core drug users. Having been referred to outpatient treatment through the CPU, these cases were matched to a more intensive intervention than they may have needed, as indicated by their OPI assessment.

Only about 7 percent of the sample would have been recommended for outpatient drug treatment on the basis of their OPI drug use severity index. Daily users of alcohol or marijuana, and individuals who use PCP or barbiturates once a week or more, are recommended for outpatient treatment (consisting of a minimum of one counseling session per week lasting at least 1 hour). Probationers who used PCP and barbiturates once a week or more, and those who used cocaine, crack, or amphetamines less than once a week, are recommended for intensive outpatient treatment (in the OPI scheme this consists of at least three 1-hour sessions per week).

Although the OPI categorizes the sample in accordance with the severity of drug use and assigns clients to various treatments depending upon their drug severity, it should be noted that all CPU clients were referred to outpatient treatment. Outpatient drug treatment was adequate (or more than adequate) for about three-quarters of the probationers (this includes the cases for which urine monitoring would have been appropriate).

Outpatient drug treatment was most effective for those clients who were appropriately matched to this treatment modality on the basis of the severity of their drug use. Given that many CPU cases had serious criminal records as well as severe drug problems, is it plausible that outpatient drug treatment, usually in modest doses, would reduce recidivism? In order to address this question, separate multiple regression analyses were conducted for the three



groups of clients having different treatment needs. At issue was whether outpatient treatment influences rearrest rates after taking into account the client's age, gender, age at first arrest, and number of prior arrests. In each of the three multiple regression analyses conducted for the three OPI groups, the four client characteristics were entered first and then treatment duration was entered. The analyses focused on determining whether the addition of the treatment variable significantly increased the amount of variance explained in rearrest rates above and beyond that of the other salient client characteristics.

In the model for the group needing residential treatment, most of the variance was explained by the client's age, gender, age at first arrest, and number of prior arrests. The addition of the treatment variable did not significantly increase the amount of variance explained. In other words, outpatient drug treatment did not lower rearrest rates among probationers whose drug use indicated a need for more structured and intensive treatment. Among those who needed urine monitoring only, the client's age, gender, age at first arrest, and number of prior arrests explained about the same amount of variance in rearrest as it did for the group needing residential treatment; however, the addition of the treatment variable increased the overall significance of the model, accounting for about an additional quarter of the total variance explained.

This suggests that outpatient treatment was effective in reducing rearrest among probationers who only needed urine monitoring according to the OPI criteria. The model for the group needing outpatient treatment had the greatest predictive power, with the treatment variable adding significantly to the explanatory power of the other predictor variables (client's age, gender, age at first arrest, and number of prior arrests). In short, this model suggests that outpatient treatment was most effective with clients who were appropriately matched to the modality on the basis of the severity of their drug use.

In conclusion, we did not find a significant reduction in rearrest rates among clients whose drug use was serious enough to warrant residential drug treatment. The most significant reductions in recidivism were found among those clients who appear to have needed outpatient drug treatment and actually received these services.

Limitations

The reader needs to be aware that the outcomes described above should be evaluated with some caution. Concerns emanate primarily from the fact that the evaluation involved a retrospective analysis of administrative data. The strength of the findings are limited because: 1) it was not possible to compare the treatment group to a no-treatment control group; 2) there were a lot of missing data on some client characteristics (e.g., employment status); and 3) self-selection may have biased the results (i.e., it is not possible to know whether clients who stayed in drug treatment longer were more motivated to succeed on probation than

those who never entered treatment or those who dropped out earlier).

There are, however, reasons for believing that the evaluation's key findings are valid. In particular, since there were relatively few significant differences between the background characteristics of the admitted and not admitted clients, but the treatment outcomes were significantly better for the group admitted to treatment than the group not admitted, one reasonably may infer that the positive outcomes are influenced by the treatment. Furthermore, since research consistently documents the fact that drug treatment does not reduce rearrest for many probationers, the finding that clients have significantly lower rearrest rates if they are appropriately referred to outpatient treatment is especially noteworthy.

Policy Implications and Recommendations

The results from this evaluation study demonstrate that if recidivism rates are to be reduced among substance-abusing probationers, these probationers need to be referred to appropriate drug treatment modalities. This finding is supported by the fact that significant reductions in rearrest rates were associated with increases in the length of outpatient drug treatment, after controlling for other variables that influence recidivism. Outpatient drug treatment clearly was not effective for the group with the most severe drug use. The findings have a number of important implications for probation policy. In general, they suggest that probation departments should refer clients to outpatient drug treatment programs, provided outpatient treatment is an appropriate modality for them:

- Contracting with outpatient drug treatment programs is a sound strategy for probationers whose use of drugs is not too severe.
- Since matching clients to appropriate forms of treatment is a key to success, it is necessary to have a variety of drug interventions. These include random urine testing and contracts or agreements with residential as well as outpatient drug treatment programs.
- Probation departments should refer clients to various treatment modalities after assessing clients' needs by utilizing instruments that measure the severity of drug use.
- Since drug treatment only can be effective if clients are actually admitted, probation officers need to ensure that clients appear for their intake appointments—making referrals is not sufficient.
- Because clients do best if they remain in treatment longer, probation departments should find ways to encourage clients to stay in treatment. Various strategies (e.g., providing positive reinforcement and supportive services) should be used to prevent clients from dropping out, especially during the critical, early stage of treatment.
- For clients in outpatient programs, it is essential to monitor attendance and progress in treatment and to take

appropriate action to ensure that they attend sessions regularly.

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NOTES

¹The contracts are funded by the New York State Office of Alcohol and Substance Abuse Services (75 percent) and the City of New York (25 percent).

²We attempted to determine the percent of cases referred to non-contracting outpatient programs and the percent not referred to treatment (in an effort to develop comparison groups); however, serious data limitations preclude our presenting reliable estimates of these percentages.